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San Francisco Health Plan 2024 Quality Improvement & Health Equity Transformation Program Evaluation

1. Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement and Health Equity Transformation Program (QIHETP) is to ensure high quality care and services for its members by proactively seeking opportunities to improve the performance of its internal operations and health care delivery system

SFHP's QIHETP is detailed in the SFHP 2024 QIHETP Description. The QIHETP Description contains an annual Work Plan, outlined in Appendix A, representing the previous year's improvement activities and measure targets. The Work Plan is reviewed twice a year as well as consolidated annually. The QIHETP Evaluation provides a detailed review of progress towards the measures and goals set forth in the QIHETP Work Plan. In this evaluation, the results are presented for six activity domains:

- Access to Primary and Specialty Care
- Care Coordination and Continuity of Care
- Clinical Quality - Behavioral Health
- Clinical Quality – Medical Care
- Engagement with Primary Care
- Member Experience

1.1 Executive Summary

1.1.1 Oversight

Under the leadership of SFHP's Governing Board, the Quality Improvement and Health Equity Committee (QIHEC) oversees the development and implementation of the QIHETP and annual QIHETP Work Plan. The QIHEC and the QIHETP are supported by multiple committees including Utilization Management, Physician Advisory/Peer Review/Credentialing, Pharmacy and Therapeutics. The QIHETP is also supported by multiple other committees including Access Compliance, Grievance Program Leadership, Grievance Review, Policy and Compliance, Provider Quality Performance Program and Provider Network Oversight. SFHP's Quality Committees, under the leadership of the Chief Medical Officer (CMO) and Chief Health Equity Officer (CHEO), ensure ongoing and systematic involvement of SFHP's staff, members, medical groups, practitioners, and other key stakeholders where appropriate.

1.1.2 Participation in the QIHETP: Leadership, Practitioners, and Staff

Senior leadership, including the CMO and Chief Health Equity Officer (CHEO), provided key leadership for the QIHETP. SFHP's Chief Executive Officer (CEO) participates in the QIHETP by championing SFHP's NCQA accreditation journey as well as an organization-wide effort to improve member care and quality of service, namely by establishing organizational strategic priorities and ensuring resources to support key initiatives. In addition, the CEO ensures that Governing Board members receive regular reports and involvement on components of the QIHETP.

The CMO provides ongoing support for all quality improvement studies and activities and was responsible for leading the Quality Improvement and Health Equity Committee; Physician Advisory/Peer Review/Credentialing Committee; Pharmacy and Therapeutics Committee; and Grievance Program Leadership. The CMO leads key clinical improvement efforts, particularly

prioritizing and recommending interventions for clinical quality performance measures as represented in the QIHETP Work Plan. The quality staff also utilize the Quality Oversight Team, comprised of leaders from across SFHP Health Services and Operations, to inform and strategize key quality initiatives.

Beyond SFHP senior leadership, SFHP achieved stakeholder participation in the QIHETP through provider and member involvement in key committees. Stakeholders participate in the Quality Improvement and Health Equity Committee and the Provider Quality Performance (PQP) Advisory Committee that advises on the pay-for-performance program. SFHP QI staff also meet with QI representatives from the provider network in quarterly quality collaborative meetings. Overall, leadership and practitioner participation in the QIHETP in 2024 was sufficient to support the execution of the QIHETP. In 2025, SFHP seeks to engage provider network leadership in quality committees and collaboratives to work together on quality activities and align QI and health equity priorities.

The QI staff is accountable for implementing the annual QIHETP Work Plan work, cross-functionally, to oversee and carry out quality improvement activities at SFHP. Staff monitor quality indicators, programs, and implement and evaluate SFHP's QIHETP work plan. In 2024, the CMO identified the need to establish a quality framework to accomplish an increasing set of quality measures that SFHP will be held accountable to, including Stars measures that will be part of SFHP's quality systems with the advent of SFHP becoming a Dual Special Needs plan in 2026. In 2025, SFHP seeks to improve quality oversight and improvement through the development and implementation of this quality framework. SFHP will also foster staff collaboration via committees, provider & clinic engagement, and workgroups to maintain and improve quality measures and activities. For a detailed summary of all staff supporting the QIHETP, please refer to the 2025 Quality Improvement & Health Equity Transformation Program Description.

1.1.3 Highlights from the 2024 QI Program Measures

SFHP had positive outcomes during the 2024 QIHETP period. Of the 25 measures included in the 2024 QIHETP Evaluation, eight, 32%, met the target. SFHP utilizes lessons learned from the 2024 QIHETP Evaluation to inform the 2025 QIHETP Work Plan and to drive continuous improvement in operations and outcomes.

In summary, SFHP identified the following areas from the QIHETP Work Plan as either demonstrating effectiveness or as opportunities for improvement.

1.1.3.1 Access to Primary and Specialty Care

Measure Title	Target Met
Appointment Availability - Routine Specialty	Yes
Provider Directory: Accuracy	No

SFHP met one of two measure targets in this domain.

Notable improvement:

- Routine Appointment Availability in Specialty Care increased by 9.0%, exceeding the target with a final rate of 57.2% of specialty providers offering routine appointments within 15 business days.

Recommendation for continued improvement:

- While Routine Appointment Availability in Specialty Care exceeded its target, improvement in this measure is a component of impacting member perception of care. Improvement in specialty care appointment access is a key driver for care experienced as measured by CAHPS and is a quality priority of SFHP.

1.1.3.2 Care Coordination and Continuity of Care

Measure Title		Target Met
Care Management Follow Up on Clinical Depression	CM	Yes
	CCM	Yes
Depression Screening and Follow-Up for Adolescents and Adults		No
Follow-Up After Emergency Department Visit for Substance Use	30 Day	No
	7 Day	No
Follow-Up After Emergency Department Visit for Mental Illness	30 Day	No
	7 Day	No

SFHP met two of seven measure targets in this domain.

Notable improvement:

- While the Follow Up After Emergency Department for Substance Use – 30 Day measure did not meet its target or the 50th percentile, the measure improved by 11.38% and moved from the 10th percentile to the 33rd percentile.

Recommendation for continued improvement:

- The Care Coordination and Continuity of Care domain had four measures related to member follow-up after emergency department visit for substance use and mental health. While all four measures improved over baseline, none of the measured reached 50th percentile. SFHP will continue to prioritize these measures in the 2025 workplan and work with providers and emergency departments to ensure timely follow-up.

1.1.3.3 Clinical Quality – Behavioral Health

Measure Title	Target Met
Adherence to Antipsychotic Medications for Individuals w/ Schizophrenia	No
Mental Health Utilization Rate	No

SFHP did not meet either of the two measure targets in this domain.

Notable improvement:

- The Mental Health Utilization Rate measure improved from 3.00% to 4.42%. While this measure did not meet its target of 4.50%, the measure improvement demonstrated greater engagement of SFHP members with the behavioral health benefits and services.

Recommendation for improvement:

- SFHP will be discontinuing both measures in the Clinical Quality – Behavioral Health domain to focus on other priorities related to behavioral health, including members receiving follow-up care after being screened for depression and members engaging in substance use treatment.

1.1.3.4 Clinical Quality – Medical Care

Measure Title	Target Met
Asthma Medication Ratio	Yes
Hepatitis C Treatment	No

SFHP met one of two measure targets in this domain.

Notable improvement:

- The Asthma Medication Ratio measure increased by 10.40% for a final result of 76.67%, moving the measure from the 50th percentile to the 90th percentile.

Recommendation for continued improvement:

- The Hepatitis C Treatment measure did not meet its target and decreased from the 2023 baseline. SFHP will continue the measure with increased collaboration with the local End Hep C initiative to educate providers and improve Hepatitis C testing.

1.1.3.5 Engagement with Primary Care

Measure Title		Target Met
Postpartum Care		No
Well-Child Visits in the First 30 Months of Life	0-15 months	Yes
	15—30 months	No
Topical Fluoride for Children		No
Initial Health Appointment		No
PCP Engagement		Yes

SFHP met two of six measure targets in this domain.

Notable improvement:

- The Well Child Visits in the First Zero to 15 Months exceeded its target by 1.44% with a final result of 59.82%. Major initiatives that brought about this improvement were collaboration with the SF Department of Public Health to collect supplemental data, incentivizing members and providers, and partnering with a clinic in SFHP's San Francisco Health Network to collaborate on multiple initiatives to address improvement in this measure.

Recommendation for continued improvement:

- The Topical Fluoride for Children measure did not meet its target, falling short by 7.31% with a result of 11.99%, falling below 2023 baseline rate of 17.77%. While SFHP conducted activities to improve this measure including offering a member incentive, SFHP must conduct more robust analysis and initiatives in the coming year to reach the target.

1.1.3.6 Member Experience

Measure Title		Target Met
HP-CAHPS	Getting Needed Care	No
	Rating of a Personal Doctor	Yes
	Rating of Specialist Seen Most Often	No

Measure Title		Target Met
Care Management Client Satisfaction	CM	Yes
	CCM	No
Provider Directory: Race & Ethnicity		No

SFHP met two of six measure targets in this domain.

Notable improvement:

- Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of a Personal Doctor increased by 4.04%, exceeding the target with a final rate of 67.58%.

Recommendation for continued improvement:

- The HP-CAHPS measure Getting Needed Care did not meet its target of 72.80% and decreased by 0.59% for a result of 69.21% which is below the 10th percentile compared to other plans. Improvement to member perception of access to care is a key quality priority, and SFHP will implement organizational initiatives to improve the member care experience including addressing workflows and system inefficiencies for Durable Medical Equipment, conducting a network analysis to understand trends and barriers to accessing specialty care appointments and services, and surveying dual-eligible members to analyze their experiences with SFHP and identify areas for improvement.

2. Evaluation

2.1 Access to Primary and Specialty Care

The Access to Primary and Specialty Care domain incorporates all aspects of the services provided to members including customer service, language access, appointment access, and wait times.

2.1.1 Routine Appointment Availability in Specialty Care

2.1.1.1 Overview & Performance

Measure: Routine Appointment Availability in Specialty Care					
Numerator	472	Baseline	48.2%	Final Performance	57.2%
Denominator	825	Target	50.0%	Evaluation Year	2024

The measure is in the Access to Primary and Specialty Care domain. Increasing timely appointment availability improves access to care for members. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care and chronic disease management to better manage their health. Increasing appointment availability may also support other QIHET program measures such as HEDIS and CAHPS, as members with timely specialty care visits are more likely to receive recommended care and members with a physician visit tend to score SFHP higher in CAHPS.

Routine Appointment Availability in Specialty Care is the total number of providers with appointments offered within 15 business days out of the total number providers surveyed in the

Provider Appointment Availability Survey in 2023, set by the Department of Managed Health Care. SFHP set a target of 50.0% based on 1.8% absolute improvement from baseline.

2.1.1.2 Activities

To improve performance, SFHP completed the activities listed below.

- Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.

2.1.1.3 Analysis

2.1.1.3.1 Quantitative

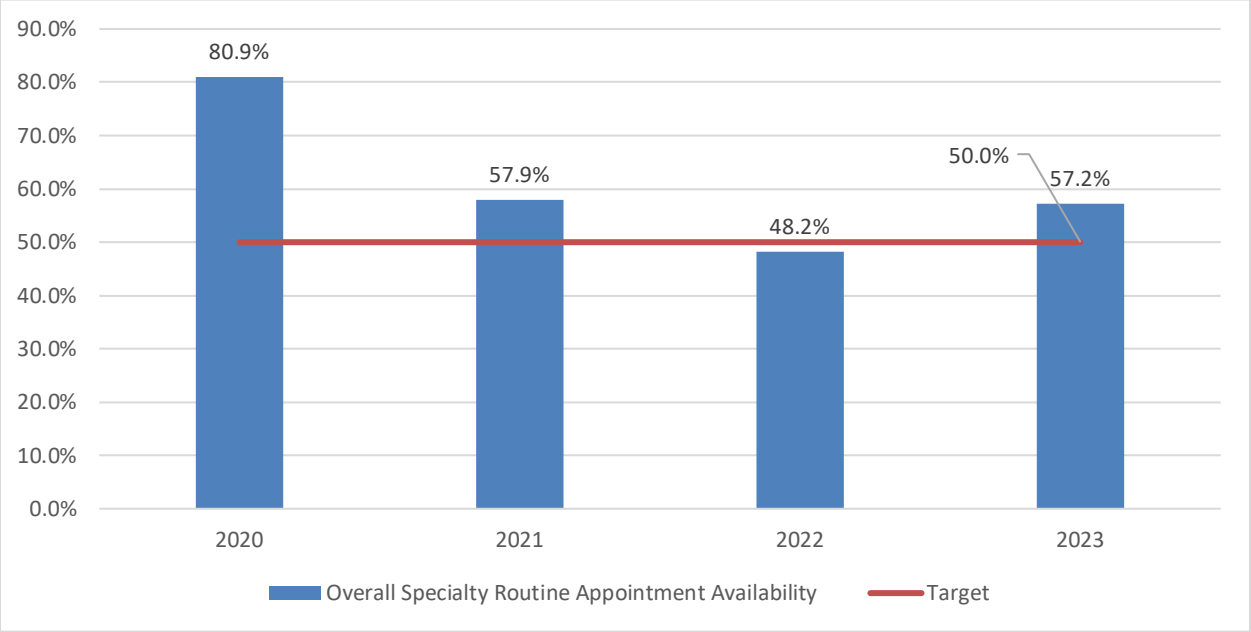
Performance increased by 9.0% from the previous measurement year, exceeding the target. 2023 performance of 57.2% compliance is on par with performance in 2021 at 57.9%.

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. The following chart demonstrates the four-year trend in routine specialty appointment availability. The table below shows the appointment availability broken down by specialty type.

Notable data points:

- Overall compliance rates for all SFHP's high volume gynecology providers increased for routine appointments from 55.7% in 2022 to 65.1% in 2023.
- Performance in 2023 included a new specialty group, Urology, which performed at 50.0%.
- The number of specialty providers that responded to the survey decreased by 436 from 2022 to 2023.

Specialty Appointment Availability 2020 – 2023



Specialty Appointment Availability Survey Denominator & Results by Provider Type

	2022 Denominator	2022 Routine Appointment Availability	2023 Denominator	2023 Routine Appointment Availability
Cardiology	131	45.8%	52	57.7%
Dermatology	49	22.4%	38	47.4%
Endocrinology	63	30.0%	46	39.1%
Gastroenterology	82	28.0%	42	52.4%
General Surgery	106	54.7%	69	52.2%
Gynecology	183	55.7%	126	65.1%
Hematology	25	48.0%	28	64.3%
Infectious Diseases	14	64.3%	28	53.6%
Nephrology	53	47.1%	51	78.4%
Neurology	121	25.6%	73	21.9%
Oncology	111	72.1%	49	65.3%
Ophthalmology	121	62.0%	66	68.2%
Orthopedics	118	58.5%	83	60.2%
Otolaryngology	51	39.2%	39	79.5%
Physical Medicine & Rehabilitation	14	50.0%	8	50.0%
Pulmonology	19	47.4%	7	71.4%
Urology	No data	No data	20	50.0%
Total	**1261**	**48.20%**	**825**	**57.2%**

2.1.1.3.2 Qualitative

SFHP faced several barriers providing timely access to care. Some barriers are more prevalent in safety net settings while others are specific to smaller practices with fewer resources to leverage.

Barriers include:

- Supply of providers – some provider groups' supply of appointments with providers is fixed due to resident and attending schedules or the number of part time providers working in a specific system or clinic. All providers in University of California San Francisco practice part time because they are also part time faculty in University of California San Francisco's academic programs.
- Variation in use of emerging appointment reminders, self-scheduling technology, and alternative visits – provider groups demonstrate uneven uptake or implementation of technologies such as telemedicine, electronic appointment reminders, and member self-

scheduling. Provider groups also show an uneven uptake of alternative visits such as nurse visits or group visits. Electronic tools are less optimized for low literacy or non-English speaking member and may require customizations or additional investments to fully leverage.

- Team based care – some clinics and health systems effectively utilize care team members to ensure good access while other settings may not be able to employ or as effectively utilize other licensed providers (e.g. health educator, pharmacist, behavioral health clinician). The Provider Appointment Availability Survey is a point-in-time survey for individual providers, so the results do not reflect appointment availability with the team-based care model.
- Electronic consult for specialty care – with the right technology in place, many consults can be managed without the need for a face-to-face visit. Different specialty care arrangements and coordination efforts as well as very recent changes in reimbursement options impact access to and timeliness of specialty care.
- Social determinants of health – transportation, housing and employment related barriers can impact members' ability to make and keep appointments. Missed appointments that go unused can contribute to poorer access.
- Barriers related to the planned activity of Corrective Action Plans:
    - Larger medical groups like University of California San Francisco and San Francisco Health Network have their own methodology to assess appointment availability access and have grieved about the Provider Appointment Availability Survey methodology. These medical groups submitted their own data to close findings where they found themselves to be compliant.
    - Independent Physician Associations have also requested that tertiary providers be removed from their Corrective Action Plan results because they do not have the authority to request improvements. Examples include University of California San Francisco providers working for Jade Health and All American Medical groups.

2.1.1.4 Recommendations

For the next evaluation period SFHP will retain this measure. However, the DMHC methodology has been updated to include holidays and weekends towards Specialty Appointment compliance. SFHP expects this change will dramatically decrease our compliance rates. Therefore, the target for this revised measure will be set at 59.0%. Activities will include:

- Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.
- Continue providing funding to Zuckerberg San Francisco General Specialty Care providers to implement appointment access interventions.
- Incentivize Zuckerberg San Francisco General providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.

2.1.2 Provider Directory – Accuracy

2.1.2.1 Overview & Performance

Measure: Provider Directory – Accuracy					
Numerator	1,113	Baseline	83.80%	Final Performance	89.76%
Denominator	1,240	Target	90.50%	Evaluation Year	2024

The Provider Directory – Accuracy measure is in the Access to Primary and Specialty Care domain. The goal of this measure is to ensure the organization's provider data in the directory is accurate and demonstrates SFHP's continued emphasis on ensuring members are able to obtain access to care. Provider Directory – Accuracy is the total number of provider data points confirmed as accurate out of the total number of data points surveyed in the reporting period. SFHP chose the target of 90.50% based on incremental improvement from the previous measurement year.

2.1.2.2 Activities

SFHP completed the activities listed below:

- Incentivized providers through inclusion of a provider roster update measure in SFHP's primary care pay-for-performance program.
- Segmented scores to identify priority groups & conducted root cause analysis of provider data errors.
- Outreached to priority provider partners identified from the root cause analysis and analyzed data to target common sources of inaccuracy.

2.1.2.3 Analysis

2.1.2.3.1 Quantitative

The data is based on the provider's information collected during the credentialling process. SFHP did not meet the 90.50% target Provider Data - Accuracy with a final rate of 89.76%, falling short of the target by 0.74%.

2.1.2.3.2 Qualitative

There were 360 providers selected for review and these produced 1,240 data points to assess. The data points included provider data elements of correct phone number, address, panel status (i.e. accepting patients or not), and operating hours. The barrier to meeting the provider directory accuracy data target is due to this information not being routinely collected through the credentialling process and because the data is updated at will by provider groups. Segmentation and root cause analysis identified the main issues with Provider Data – Accuracy:

- San Francisco Health Network, SFHP's provider group providing care to the majority of SFHP's members, and Carelon, SFHP's behavioral health network, both had outdated provider data.
- University of California San Francisco provider group's provider data was inaccurate due to many providers moving locations over the course of the year.

2.1.2.4 Recommendations

SFHP will discontinue the Provider Data – Accuracy in the QIHET Program; SFHP's Provider Network Operations staff will continue to monitor and work to improve provider data.

2.2 Care Coordination and Continuity of Care

The domain of Care Coordination and Continuity of Care involves activities related to Long Term Care Quality, Care Transitions, Care Management, Enhanced Care Management, monitoring of over and underutilization, and otherwise improved coordination across multiple providers and facilities and focuses on members with more complex medical and psychosocial needs.

2.2.1 Care Management Follow-Up on Clinical Depression

2.2.1.1 Overview & Performance

Measure: Care Management Follow-Up on Clinical Depression					
Numerator	3	Baseline	85.71%	Final Performance	100%
Denominator	3	Target	90.00%	Evaluation Year	2024
Measure: Complex Care Management Follow-Up on Clinical Depression					
Numerator	1	Baseline	85.00%	Final Performance	100%
Denominator	1	Target	87.00%	Evaluation Year	2024

The Care Management Follow-Up on Clinical Depression measure is in the Care Coordination and Continuity of Care domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) and Complex Care Management (CCM) programs who screen positive for depression symptoms via the Patient Health Questionnaire (PHQ-9) depression screening tool and are connected to services for care via SFHP Care Management staff coordination. This measure represents SFHP's commitment to ensuring that Care Management programs are member-centered, and address follow up care for members with behavioral health needs. The target for this measure was 90.0% for Care Management clients and 87.0% for Complex Care Management based on incremental improvement from the previous measurement year.

2.2.1.2 Activities

The following activities were completed:

- Clinical Supervisors conducted audits every 4 months to ensure best practices and regulatory requirements were met.
- Clinical Supervisors reviewed CM dashboard monthly with staff and to coach staff to ensure members were screened and received appropriate follow up.
- Collaborated to ensure effective coordination of care through the Managed Behavioral Health Care Committee which includes both SFHP and SF Behavioral Health Services.
- Completed quarterly staff self-audits which enabled Care Management staff to identify

and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.

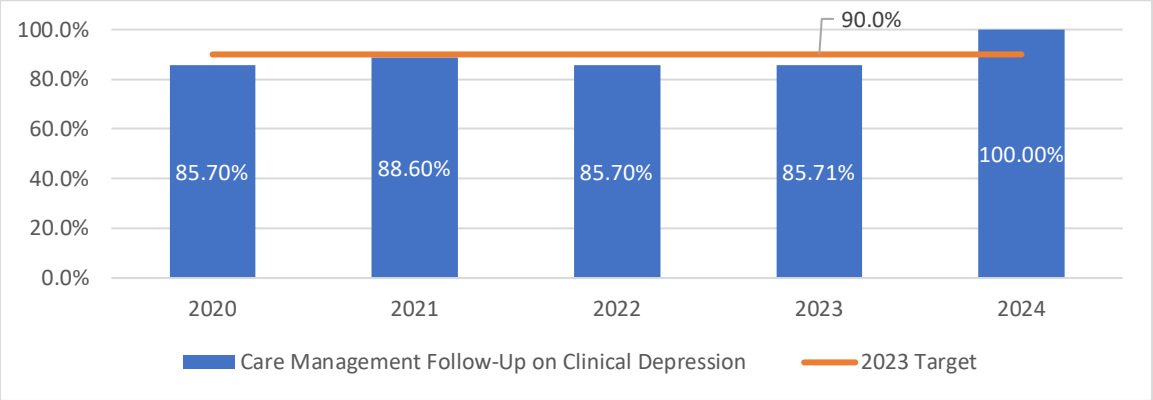
- Initiated a weekly behavioral health office hour between SFHP Care Management, SFHP Behavioral Health, and Carelon clinical teams to ensure timely connection to behavioral health services.
- Trained staff in mental health, particularly on severe mental illness and community resources, to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety, including connection to behavioral health services.

2.2.1.3 Analysis

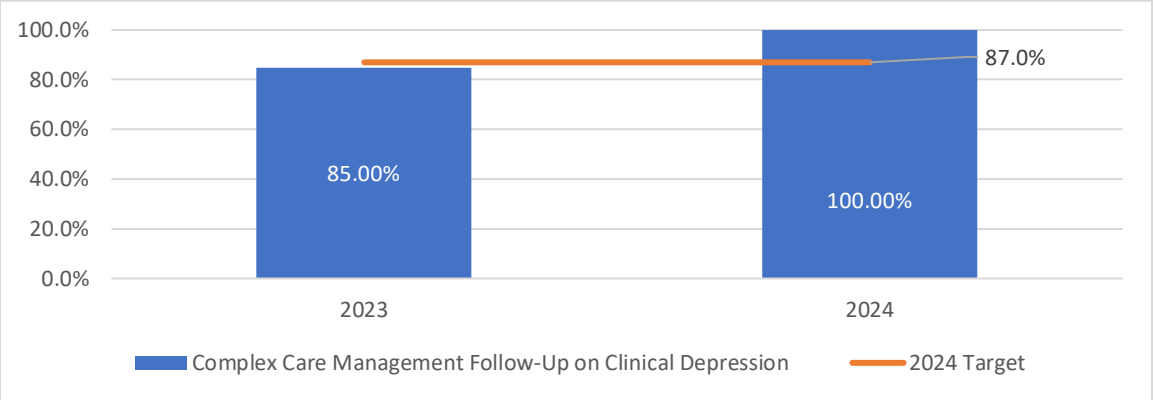
2.2.1.3.1 Quantitative

SFHP exceeded the CM target of 90.0% by 10% with a final result of 100% and the CCM target of 87% by 13% with a final result of 100%. The following charts demonstrates the year over year trend in the rate of members with Care Management Follow-Up on Clinical Depression and Complex Care Management Follow-Up on Clinical Depression.

Care Management Follow-Up on Clinical Depression 2020 – 2024



Complex Care Management Follow-Up on Clinical Depression 2023 – 2024



2.2.1.4 Recommendations

SFHP will discontinue the CM & CCM Follow-Up on Clinical Depression measures in the QIHET Program and focus on Care Coordination and Continuity of Care efforts as measured by HEDIS

for SFHP's Medi-Cal population. SFHP's Care Management staff will continue to work to assess members for depression and coordinate follow-up with appropriate care.

2.2.2 Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

2.2.2.1 Overview & Performance

Measure: Depression Screening – Follow-Up for Adolescents and Adults (DSFE)					
Numerator	1,555	Baseline	69.69%	Final Performance	64.44%
Denominator	2,413	Target	85.00%	Evaluation Year	2024

The Depression Screening – Follow-Up for Adolescents and Adults (DSF-E) measure is in the Care Coordination and Continuity of Care domain. This measure reflects activities intended to increase the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days. This measure represents SFHP's commitment to ensuring that members receive follow up care for members with behavioral health needs and aligns with DHCS bold goals and comprehensive quality strategy. The target for this measure was 85.00% based on returning to 2022 rates of follow-up from depression screening as this measure did not have percentile benchmarks at the time of setting the measure target as benchmarks were not published until October 2024.

2.2.2.2 Activities

The following activities were completed:

- Disseminated depression screening health education to members in the member newsletter, Your Health Matters.
- Discussed depression screening and follow-up with provider groups and planned to include depression screening and follow-up as measures to target improvement in the Provider Quality Performance program in 2025, SFHP's pay-for-performance program.

The following activities were not completed:

- Conduct member-outreach campaign encouraging treatment of symptoms of depression.
- Track Carelon Care Management staff completing PHQ-9 depression screening on all members who are referred to Carelon mental health services.
- Match primary care clinics which screen for depression with culturally congruent mental health providers for follow-up care.
- Collaborate with SFHP's mental health provider Carelon and SFHP's provider group which serves the largest portion of Asian identifying and Chinese-speaking members North East Medical Services to increase referrals.
- Improve provider credentialing issue with North East Medical Services and other provider groups to increase members' access to behavioral health providers.

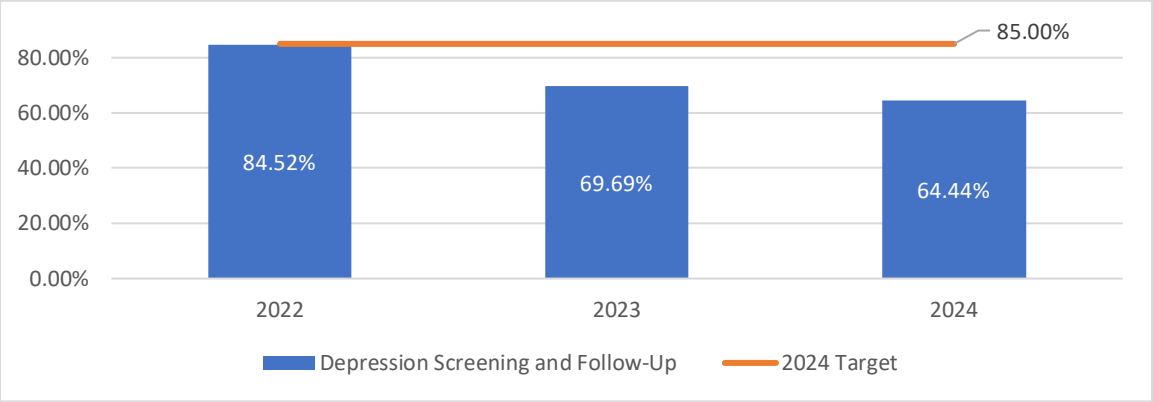
- Coordinate with Carelon to bring APA Family Support Services, a behavioral health provider serving the Chinese community, into Carelon's contracted network.

2.2.2.3 Analysis

2.2.2.3.1 Quantitative

The final result of 33.12% fell short of the target of 85.00% by 20.56%. The result of 33.12% reached the 25th percentile compared to other health plans.

Depression Screening and Follow-Up for Adolescents and Adults 2022—2024



2.2.2.3.2 Qualitative

A barrier to completing planned activities included staffing changes at SFHP, as the Behavioral Health Manager started mid-way through 2024. One barrier to meeting the target was accessibility including appointment availability, as identified from care experience surveys and member grievances. Limited access to evening or weekend appointment times and availability of childcare for members' visits represented barriers to members attending therapy appointments. Another barrier to reaching the target is the lack of co-located primary care and behavioral healthcare providers

2.2.2.4 Recommendations

SFHP will continue this measure in 2025 with a target of 70.97% to reach the 50th percentile and activities to support this measure will include:

- Incentivize providers through inclusion of depression screening and follow-up measures in SFHP's primary care pay-for-performance program.
- Provide gap in care reports to providers for members eligible for depression screening and follow-up.
- Collaborate with Primary Care Providers to co-locate behavioral health staff onsite at clinics
- Deliver member and provider education materials on the benefits and importance of dyadic care services

2.2.3 Follow up After Emergency Department for Substance Use (FUA)

2.2.3.1 Overview & Performance

Measure: Follow up After Emergency Department for Substance Use – 30 Day (FUA-30)					
Numerator	563	Baseline	21.74%	Final Performance	33.12%
Denominator	1,700	Target	36.34%	Evaluation Year	2024
Measure: Follow up After Emergency Department for Substance Use – 7 Day (FUA-7)					
Numerator	337	Baseline	12.14%	Final Performance	19.82%
Denominator	1,300	Target	24.51%	Evaluation Year	2024

The Follow up After Emergency Department for Substance Use (FUA) measure is in the Care Coordination and Continuity of Care domain. This measure calculates the percentage of SFHP members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within seven (FUA-7) or 30 (FUA-30) days after ED visit, out of the total number of SFHP members who had an ED visit with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.

Timely follow-up care for individuals who were seen in an emergency department for a substance use disorder is associated with reduced hospital use and increased treatment adherence. Coordination of care for such individuals requires information-sharing between hospitals and primary care providers that may not occur under existing/standard workflows.

SFHP chose a target of 36.34% for FUA-30 measure and 24.51% for FUA-7. These targets were chosen based on the 2022 NCQA Medicaid 50th percentile benchmark and to demonstrate significant improvement from SFHP's baseline rate of 21.74% (FUA-30) and 12.14% (FUA-7). The 2022 NCQA 50th percentile target for FUA-30 is also aligned with DHCS requirements to meet minimum performance level for that measure.

2.2.3.2 Activities

The following activities were completed:

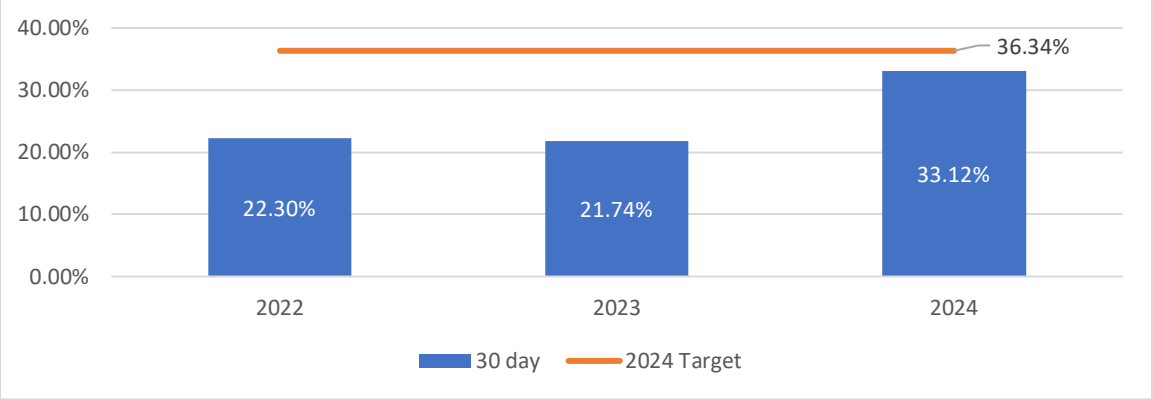
- Emergency Department Navigators assisted members with connection to members' Enhanced Care Management provider or PCP to schedule a follow-up visit.
- Developed a reporting process to routinely share ED visit data with network primary care providers within seven days of the member's ED admission to facilitate follow-up outreach and scheduling of a PCP appointment.
- Incentivized providers through inclusion of a FUA-30 measure in SFHP's primary care pay-for-performance program.

2.2.3.3 Analysis

2.2.3.3.1 Quantitative

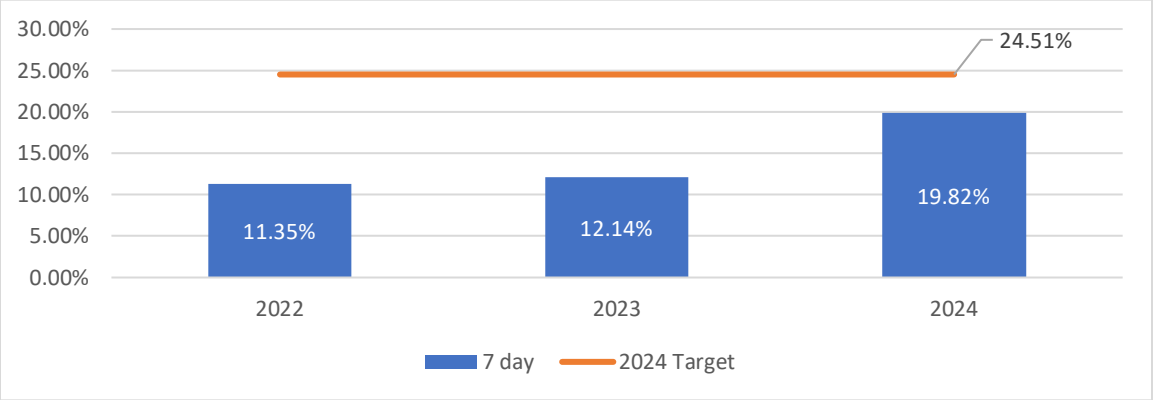
For Follow Up After Emergency Department for Substance Use – 30 Day, the final result of 33.12% fell short of the target of 36.34% by 3.22%. The result of 33.12% reached the 33rd 2023 NCQA percentile.

Follow Up After Emergency Department for Substance Use – 30 Day 2022—2024



For Follow Up After Emergency Department for Substance Use – Seven Day, the final result of 19.82% fell short of the target of 24.51% by 4.69%. The result of 19.82% reached the 33rd 2023 NCQA percentile.

Follow Up After Emergency Department for Substance Use – Seven Day 2022—2024



2.2.3.3.2 Qualitative

Barriers to meeting the FUA-7 and FUA-30 targets include:

- Extensive amounts of time spent on the phone by ED Navigators trying to connect members to primary care providers or care managers for scheduling follow-up appointments; many members will not wait on hold to complete necessary processes.
- Lack of accurate and timely patient data when notifying Primary Care Providers about their members' presenting to the ED reducing amount of time for PCPs to outreach and schedule patients for follow-up appointments.

- Members admitting to ED after-hours creating difficulty or inability to schedule patient for follow-up visit upon discharge from emergency department.
- Consistent no-show by members who scheduled an appointment for follow-up.

2.2.3.4 Recommendations

SFHP will continue this measure in 2025 with a target of 36.18% or 50th percentile (FUA-30) and 24.00% or 50th percentile (FUA-7) and activities to support this measure will include:

- Share with network providers ED visit data of members eligible for Follow-Up After ED Visit for Substance Use to facilitate follow-up outreach and scheduling of a PCP appointments.
- Provide training to ED Navigators on SFHP's recommended workflow for connecting members to their primary care provider and/or care manager.
- Collaborate with contracted Emergency Departments to improve ED Navigators patient documentation practices, including the attachment of visit notes to hospital charts and use of Health Information Exchange, to support better sharing of information between hospitals and primary care providers.
- Identify mental health providers with availability after-hours and generate a directory to share with ED Navigators.
- Incentivize providers through inclusion of a Follow-Up After ED Visit for Substance Use 30-day measure in SFHP's primary care pay-for-performance program.

2.2.4 Follow up After Emergency Department for Mental Health (FUM)

2.2.4.1 Overview & Performance

Measure: Follow up After Emergency Department for Mental Health – 30 Day (FUM-30)					
Numerator	520	Baseline	27.48%	Final Performance	44.29%
Denominator	1,174	Target	54.87%	Evaluation Year	2024
Measure: Follow up After Emergency Department for Mental Health – 7 Day (FUM-7)					
Numerator	372	Baseline	18.06%	Final Performance	31.69%
Denominator	1,174	Target	40.59%	Evaluation Year	2024

The Follow up After Emergency Department for Mental Health (FUM) measure is in the Care Coordination and Continuity of Care domain. This measure calculates the percentage of SFHP members age six and older who received a follow-up visit for mental illness within seven (FUM-7) and 30 (FUM-30) of an emergency department visit with a diagnosis of mental illness or intentional self-harm out of the total number of SFHP members who had an ED visit with a diagnosis of mental illness or intentional self-harm.

Timely follow-up care for individuals who were seen in an emergency department for mental health is associated with reduced hospital use and increased treatment adherence. Coordination of care for such individuals requires information-sharing between hospitals and primary care providers that may not occur under existing/standard workflows.

SFHP chose a target of 54.87% (FUM-30) and 40.59% (FUM-7). These targets were chosen and to demonstrate significant improvement from SFHP's baseline rate of 27.48% (FUM-30) and 18.06% (FUM-7). The 50th percentile target for FUM-30 is also aligned with DHCS requirements to meet the minimum performance level for that measure.

2.2.4.2 Activities

The following activities were completed:

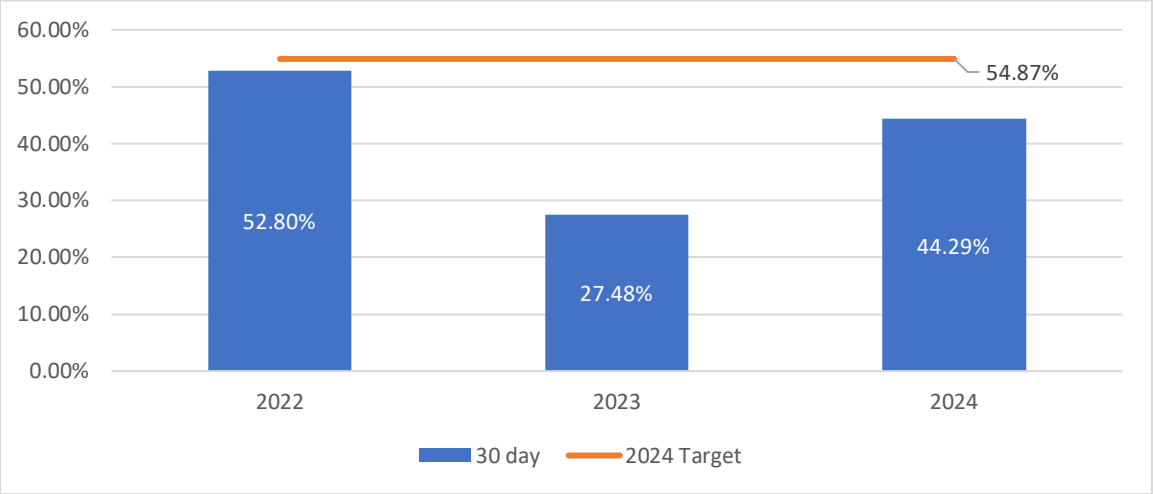
- Emergency Department Navigators assisted members with connection to members' Enhanced Care Management provider or PCP to schedule a follow-up visit.
- Developed a reporting process to routinely share ED visit data with network primary care providers within seven days of the member's ED admission to facilitate follow-up outreach and scheduling of a PCP appointment.
- Incentivized providers through inclusion a FUM-30 measure in SFHP's primary care pay-for-performance program.

2.2.4.3 Analysis

2.2.4.3.1 Quantitative

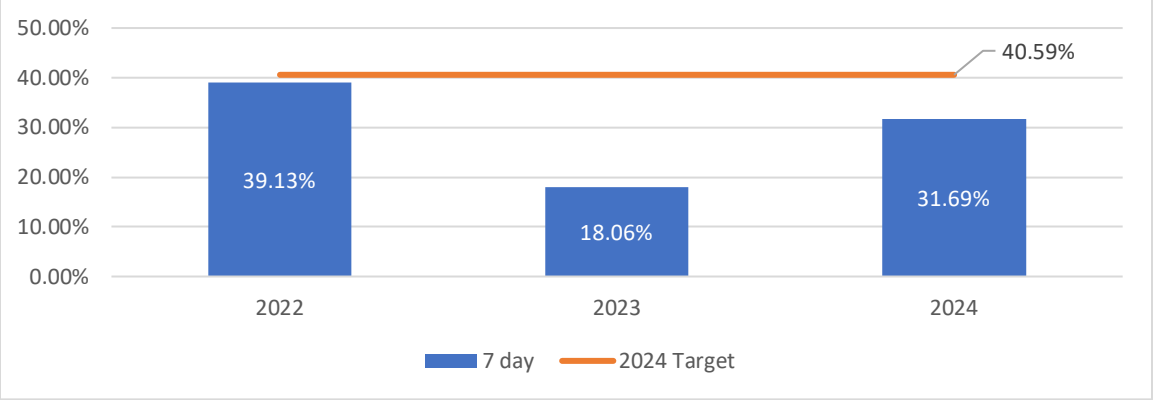
For Follow Up After Emergency Department for Mental Health – 30 Day, the final result of 44.29% fell short of the target of 54.87% by 10.58%. The result of 44.29% reached the 10th percentile compared to other health plans.

Follow Up After Emergency Department for Mental Health – 30 Day



For Follow Up After Emergency Department for Mental Health – Seven Day, the final result of 31.69% fell short of the target of 40.59% by 8.90%. The result of 31.69% reached the 25th percentile compared to other health plans.

Follow Up After Emergency Department for Mental Health – 7 Day



2.2.4.3.2 Qualitative

Barriers included:

- Extensive amounts of time spent on the phone by ED Navigators trying to connect members to primary care providers or care managers for scheduling follow-up appointments; many members will not wait on hold to complete necessary processes to obtain appointments.
- Lack of accurate and timely patient data when notifying Primary Care Providers about their members' presenting to the ED reducing amount of time for PCPs to outreach and schedule patients for follow-up appointments.
- Members admitted to ED after-hours made it difficult to schedule patient for follow-up visit upon discharge from emergency department.
- Providers reported a pattern of no-show by members who scheduled an appointment for follow-up.

2.2.4.4 Recommendations

SFHP will continue this measure in 2024 with a target of 53.82% (FUM-30) and 38.62% (FUM-7) and activities to support this measure will include:

- Share with network providers ED visit data of members eligible for Follow-Up After ED Visit for Mental Illness to facilitate follow-up outreach and scheduling of a PCP appointments.
- Provide training to ED Navigators on SFHP's recommended workflow for connecting members to their primary care provider and/or care manager.
- Collaborate with contracted Emergency Departments to improve ED Navigators patient documentation practices, including the attachment of visit notes to hospital charts and

use of Health Information Exchange, to support better sharing of information between hospitals and primary care providers.

- Identify mental health providers with availability after-hours and generate a directory to share with ED Navigators.
- Incentivize providers through inclusion of a Follow-Up After ED Visit for Mental Illness 30-day measure in SFHP's primary care pay-for-performance program.

2.3 Clinical Quality - Behavioral Health

The domain of Clinical Quality – Behavioral Health involves activities related to clinical outcomes of behavioral health chronic condition care management.

2.3.1 Antipsychotic Medication Adherence (SAA)

2.3.1.1 Overview & Performance

Measure: Antipsychotic Medication Adherence (SAA)					
Numerator	197	Baseline	58.32%	Final Performance	57.77%
Denominator	341	Target	61.39%	Evaluation Year	2024

The Antipsychotic Medication Adherence (SAA) is in the Clinical Quality – Behavioral Health domain. This rate is based on members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. Increasing SAA reflects improved management for members with behavioral health conditions. SFHP chose the target of 61.39% based on national HEDIS benchmarks. Increasing SFHP's SAA rate would place SFHP in the 2022 NCQA 50th percentile of plans for this measure.

2.3.1.2 Activities

The following activities were completed:

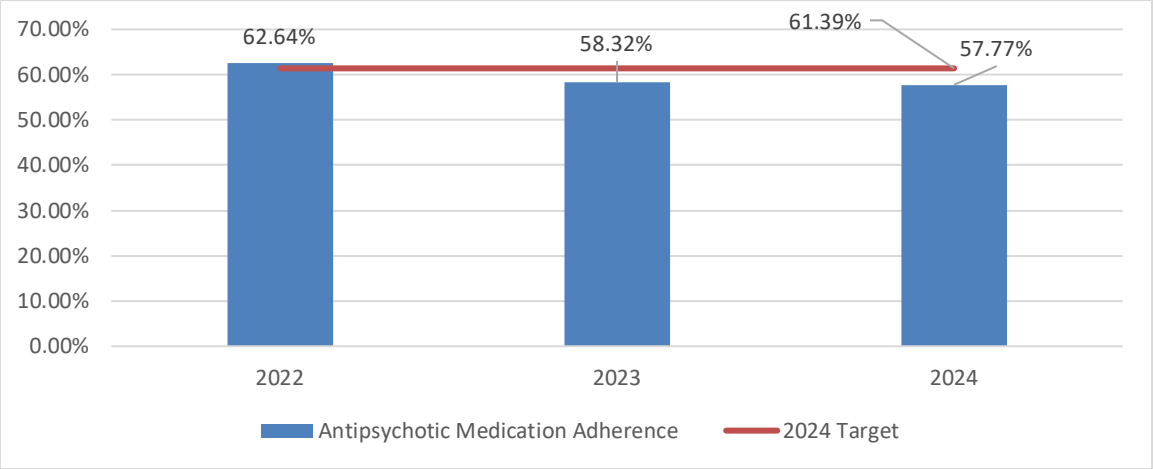
- Shared SAA data with San Francisco Department of Public Health, who handles all moderate to severe mental health diagnoses including schizophrenia.
- Discussed barriers to antipsychotic adherence and access for members with schizophrenia on antipsychotics with San Francisco Behavioral Health Services.
- Created a drug utilization review report to monitor antipsychotic adherence.
- Included member education on medication adherence for chronic disease states in the Fall 2024 Your Health Matters member health education newsletter.

2.3.1.3 Analysis

2.3.1.3.1 Quantitative

SFHP did not meet the target of 61.39%, falling short by 3.62% with a final result of 57.77%. The result of 57.77% reached the 2023 NCQA 25th percentile.

Antipsychotic Medication Adherence 2022—2024



2.3.1.3.2 Qualitative

Barriers to meeting the target coincide with the challenges that members with schizophrenia face in maintaining their care. Patients with schizophrenia are often disconnected with care or may be reluctant to begin or continue medication. SFHP has continued to work with San Francisco Department of Public Health to mitigate barriers that members with schizophrenia face.

2.3.1.4 Recommendations

SFHP will discontinue the Antipsychotic Medication Adherence measure in the QIHET Program and focus on other Clinical Quality – Behavioral Health measures.

2.3.2 Mental Health Utilization Rate

2.3.2.1 Overview & Performance

Measure: Mental Health Utilization Rate					
Numerator	9,950	Baseline	3.00%	Final Performance	4.42%
Denominator	224,926	Target	4.50%	Evaluation Year	2024

The Mental Health Utilization Rate is in the Clinical Quality – Behavioral Health domain. Increasing mental health utilization reflects improved access for members with behavioral health conditions. The measure is the percentage of distinct Medi-Cal members utilizing the non-specialty mental health benefit who had at least one visit with a behavioral health provider from October 1, 2023, to September 30, 2024.

Data is based on non-specialty mental health claims paid by Carelon, SFHP's Behavioral Health provider. The baseline rate of 3.00% was based on a broad set of mental health therapy claim codes and SFHP set the target of 4.50% based on 1.50% absolute improvement from this initial baseline.

2.3.2.2 Activities

The following activities were completed:

- Developed an outreach and education plan for members and primary care providers about behavioral health services.
- Implemented improved service-level agreement with Carelon to hold them accountable to care improvements including:
    - Requiring 90% of members requesting an appointment to receive the appointment within 10 business days for therapy and 15 business days for psychiatry.
    - Increasing the number of culturally relevant providers that speak Cantonese, Mandarin, or Spanish aligned with member preference.

The following planned activities were not completed:

- Increase integration of clinics to include providers of behavioral therapy.
- Implement dyadic care services to improve family well-being through care appointments that are scheduled in tandem to support parent and child health.

2.3.2.3 Analysis

2.3.2.3.1 Quantitative

SFHP did not meet the target of 4.50%, falling short by 0.08% with a final result of 4.42%.

2.3.2.3.2 Qualitative

A barrier to completing planned activities included staffing changes at SFHP, as the Behavioral Health Manager started mid-way through 2024. A barrier to meeting the target was accessibility including appointment availability, as identified from the care experience surveys and member grievances. Limited access to evening or weekend appointment times and availability of childcare for members' visits represented barriers to members attending therapy appointments.

2.3.2.4 Recommendations

SFHP will discontinue the Mental Health Utilization measure in the QIHET Program and focus on other Clinical Quality – Behavioral Health measures.

2.4 Clinical Quality – Medical Care

The domain of Clinical Quality – Medical Care involves activities related to clinical outcomes related to chronic condition care management, patient safety, and pharmacy services including drug utilization review.

2.4.1 Asthma Medication Ratio (AMR)

2.4.1.1 Overview & Performance

Measure: Asthma Medication Ratio (AMR)					
Numerator	641	Baseline	66.27%	Final Performance	76.67%
Denominator	836	Target	69.41%	Evaluation Year	2024

The Asthma Medication Ratio measure is in the Clinical Quality – Medical Care domain. This measure calculates the percentage of SFHP members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 out of the total number of SFHP members who were identified as having persistent asthma. SFHP chose a target of 69.41%. This target was chosen based on the 2022 NCQA Medicaid 50th percentile benchmark and to represent incremental improvement from SFHP's baseline rate of 66.27%.

2.4.1.2 Activities

The following planned activities were completed:

- Collaborated with provider groups with the most opportunity for improvement.
- Created a chart of maintenance inhalers and communicated updated asthma guidelines with providers and pharmacies.
- Mailed out asthma educational handout to over 50 members identified as noncompliant.
- Incentivized providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program.
- Promoted and encouraged members with asthma to engage in services through a Chronic Condition incentive.

The following activities were not completed:

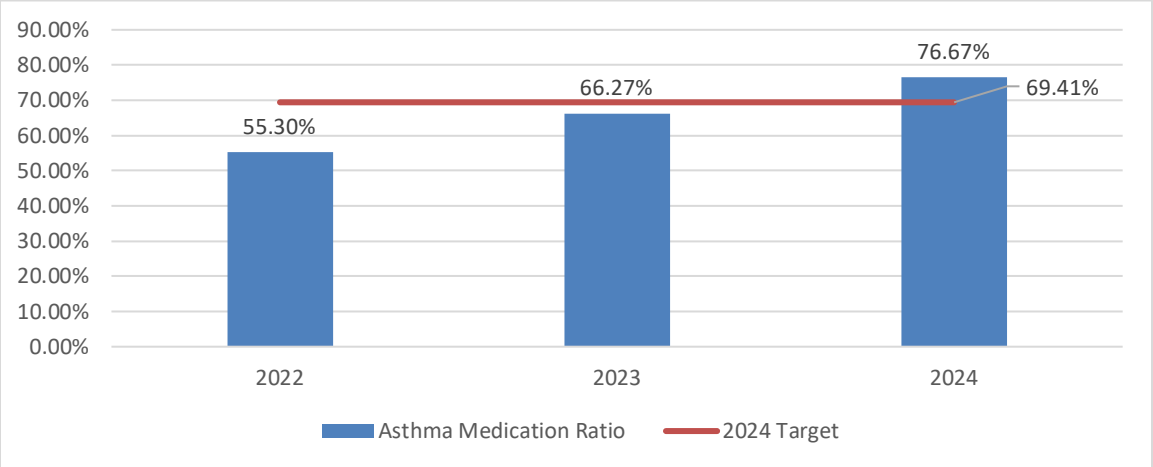
- Conduct root cause analysis of why certain groups are experiencing disparities.
- Ideate and explore equity-focused interventions for groups experiencing disparities.

2.4.1.3 Analysis

2.4.1.3.1 Quantitative

SFHP met the target of 69.41%, exceeding it by 7.26% with a final result of 76.67%, putting SFHP in the 2023 NCQA 90th Medicaid percentile.

Antipsychotic Medication Adherence 2022—2024



2.4.1.4 Recommendations

SFHP will continue this measure in 2025 with a target of 76.65% to maintain the NCQA 90th percentile. Activities to support this measure will include:

- Continue to create educational materials for providers around the Global Initiative for Asthma guidelines.
- Incentivize providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program. ·
- Discontinue the Chronic Condition member incentive which promotes and encourages members with chronic conditions including asthma to engage in primary care services through and launch a new Asthma member incentive to address members needing intervention to address their Asthma medications.

2.4.2 Hepatitis C Treatment

2.4.2.1 Overview & Performance

Measure: Hepatitis C Treatment					
Numerator	1,365	Baseline	35.97%	Final Performance	30.76%
Denominator	4,437	Target	40.00%	Evaluation Year	2024

The Hepatitis C Treatment measure is in the Clinical Quality – Medical Care domain. This rate is based on the total number of SFHP members with any past history of Hepatitis C diagnosis who have completed the Hepatitis C treatment regimen within the last 36 months. The measure benefits members because treatment can prevent the spread of Hepatitis C disease and lowers the risk of liver disease. The target of 40.0% was selected based on incremental improvement from 2023 final performance.

2.4.2.2 Activities

The following planned activities were completed:

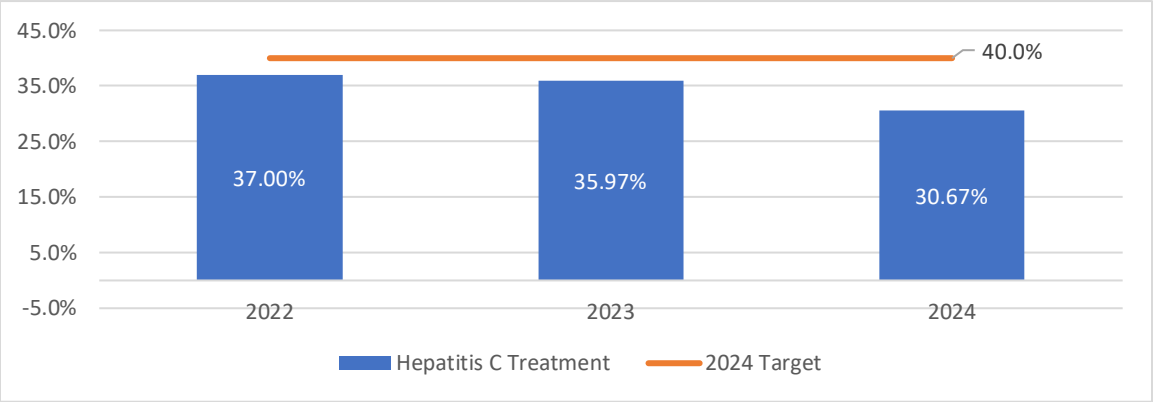
- Provided analysis and trends on members who have not completed Hepatitis C treatment to providers.
- Meet with local initiative group End Hep C to align SFHP with other city efforts around Hepatitis C.

2.4.2.3 Analysis

2.4.2.3.1 Quantitative

SFHP did not meet the target of 40.00%, missing it by 9.33% with a final result of 30.67%.

Hepatitis C Treatment 2022 – 2024



2.4.2.3.2 Qualitative

Barriers to reaching the target included:

- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to complete the long course of treatment may have had an impact on the measure reaching the target.
- Insurance status of people with Hepatitis C. The local initiative group End Hep C found in their research this past year that the largest group of people with untreated Hep C are uninsured. Future efforts to improve this measure must address continuity of members insurance status.

2.4.2.4 Recommendations

SFHP will continue this measure in 2024. And the target will remain 40.00% and activities to support this measure will include:

- Collaborate with End Hep C group on provider education and C to promote Hepatitis C testing in the community.
- Provide analysis and trends on members who have not completed Hepatitis C treatment to providers.
- Create outreach letter template for providers with members with a diagnosis of Hepatitis C who have not yet received treatment.

2.5 Engagement with Primary Care

The domain of Engagement with Primary Care involves activities related to the delivery of preventative care services and Initial Health Assessments.

2.5.1 Postpartum Care (PPC-Post)

2.5.1.1 Overview & Performance

Measure: Postpartum Care (PPC-Post)					
Numerator	873	Baseline	76.02%	Final Performance	80.39%
Denominator	1,086	Target	84.59%	Evaluation Year	2024

The Postpartum Care measure is in the Engagement with Primary Care domain. This rate is based on the total number of birthing SFHP members who have received a postpartum care visit between seven and 84 days after delivery, out of the total number of birthing SFHP members. This HEDIS measure is a hybrid measure, which means that SFHP won't have final rates until we complete medical record review in May 2025. For this reason, SFHP will be evaluating the measure based on the Nov 2024 proactive run rate, which includes the entire eligible population, rather than the sample required for hybrid rate reporting. SFHP chose the target of 84.59% based on the 2022 NCQA Medicaid 90th percentile benchmark.

2.5.1.2 Activities

The following activities were completed:

- Built a network of doulas and community health workers to support all members engaging in perinatal care and connecting with plan benefits and services.
- Developed a Postpartum Toolkit that addresses several key topics: doula services, community health workers, postpartum care, and maternal child health rewards programs.
- Promoted and encouraged pregnant members to engage in services through a member incentive for both prenatal and postpartum visits. In 2024 SFHP provided 1,441 gift card member incentives, representing 2% of members eligible to obtain the incentive.
- Incentivized providers through inclusion of a prenatal visit measure in SFHP's primary care pay-for-performance program. While postpartum visits were not incentivized for providers, providers engaging with pregnant members in the prenatal period served to establish a connection to care through birth and the postpartum period.
- Incentivized providers through inclusion of a perinatal health equity measure in SFHP's primary care pay-for-performance program. Two of SFHP's contracted provider groups Brown & Toland Physicians and North East Medical Services chose to conduct perinatal quality improvement health equity activities for members who were Hispanic or Latino, Black or African American, Native American, and Asian or Other Pacific Islander.

The following activity was not completed:

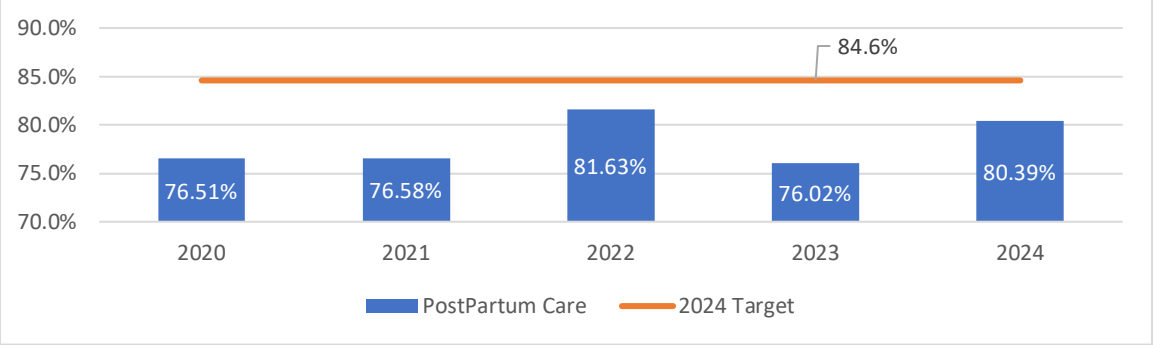
- Build an outreach program using a diverse group of staff to reach out to at-risk persons who are less likely to engage in preventive care. Refer pregnant members to community health workers and doulas for support and intervention.

2.5.1.3 Analysis

2.5.1.3.1 Quantitative

SFHP did not meet the target of 84.59%, falling short by 4.20% with a final result of 80.39%. However, SFHP did improve over the baseline rate and SFHP achieved the 2023 NCQA 50th Medicaid percentile.

Post-Partum Care 2020 – 2024



2.5.1.3.2 Qualitative

The main barrier to reaching the target and completing one of the planned activities was the lack of population health management staffing resources to conduct activities to support the improvement of this measure. While SFHP promoted the use of doula services and community health workers for this population, use of these benefits and services among pregnant members remain low. While SFHP did not reach the target, SFHP expects that the supplemental medical record review process ending in May 2025 to obtain hybrid rates for this measure will likely result in achieving the target.

2.5.1.4 Recommendations

SFHP will discontinue the PPC-Post measure in the QIHET Program and focus on other Engagement in Primary Care measures. DHCS will continue to hold Medi-Cal plans accountable for PPC-Post through financial penalty. While SFHP will not be developing new interventions for this measure for 2025, SFHP will track and monitor the performance to ensure that the plan achieves at minimum the 66th percentile for final hybrid rates.

2.5.2 Well Child Visits in the First 30 Months (W30)

2.5.2.1 Overview & Performance

Measure: Well Child Visits in the First 0—15 Months (W30-6)					
Numerator	262	Baseline	53.94%	Final Performance	59.82%
Denominator	438	Target	58.38%	Evaluation Year	2024
Measure: Well Child Visits in the First 15—30 Months (W30-2)					
Numerator	980	Baseline	72.73%	Final Performance	72.86%
Denominator	1,345	Target	77.78%	Evaluation Year	2024

The Well Child Visits in the First 30 Months (W30) measure indicators is in the Engagement with Primary Care Domain. The W30-6 indicator calculates the percentage of SFHP members age zero to 15 months who receive six or more well-child visits out of the total number of SFHP members age zero to 15 months. The W30-2 indicator calculates the percentage of SFHP members age 15 to 30 months who receive two or more well-child visits out of the total number of SFHP members age 15 to 30 months. This measure allows SFHP to improve child health and engagement with a primary care practitioner. SFHP chose targets of 58.38% (W30-6) and 77.78% (W30-2). These targets were chosen based on the 2022 NCQA Medicaid 50th percentile (W30-6) and 90th percentile (W30-2) benchmarks and represent significant improvement from SFHP's baseline rates of 53.38% (W30-6) and 72.73% (W30-2).

2.5.2.2 Activities

The following activities were completed:

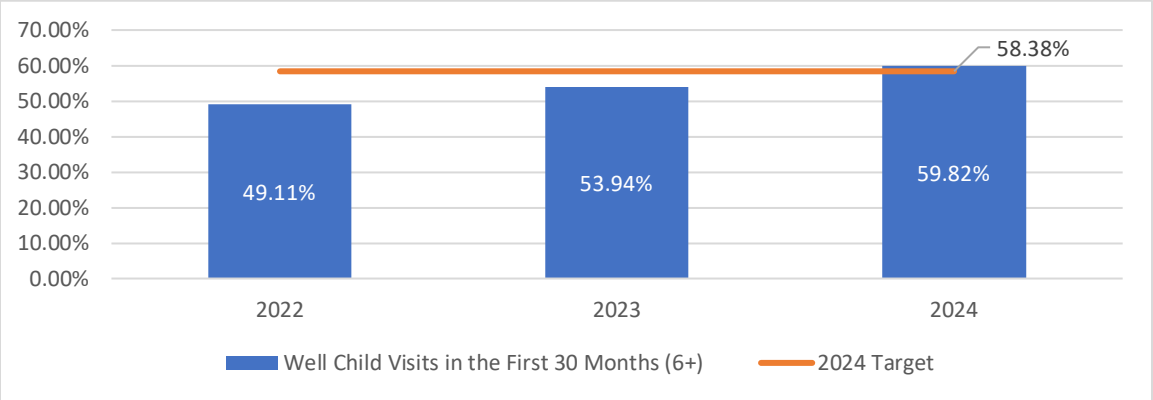
- Collaborated with SF Department of Public Health and other health plans on coordinated effort to improve measure including through collecting supplemental data to demonstrate well child visits that occurred but were not originally captured via provider encounter data.
- Completed a Maternal & Child Health gap analysis to determine what are the barriers to care and improvement of W30 and created an infant wellness map.
- Promoted and encouraged members age zero to 15 months to engage in services through a member incentive to obtain well-child visits. In 2024 SFHP provided 375 gift card member incentives, representing 20% of members eligible to obtain the incentive.
- Conducted an initiative to partner with a clinic in SFHP's San Francisco Health Network to address health disparities. SFHP also conducted a Plan-Do-Study-Act quality improvement project with the same clinic to test providing member incentives in-person.
- Incentivized providers through inclusion of a W30-6 measure in SFHP's primary care pay-for-performance program.
- Incentivized providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers participating in this activity conducted well-child quality improvement & health equity activities for the measure for members who are Hispanic or Latino and Black or African American. Five of SFHP's contracted provider networks (All American Medical Group, Hill Physicians, Jade Health, San Francisco Health Network, University of California San Francisco) and two community clinics (Mission Neighborhood Health Center, St. Anthony's Medical Clinic) participated in this health equity initiative.

2.5.2.3 Analysis

2.5.2.3.1 Quantitative

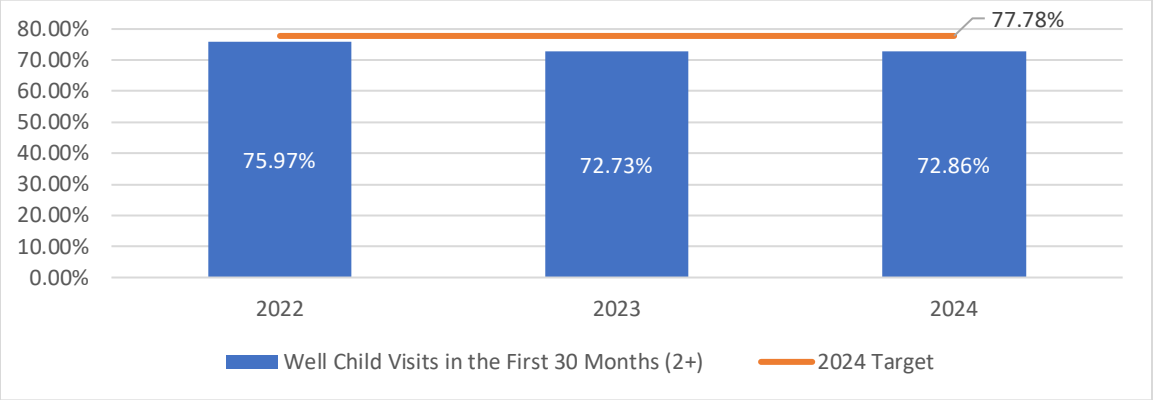
For the W30-6 indicator, the final result of 59.82% met the target of 58.38%, exceeding it by 1.44% and meeting the 2023 NCQA 33rd percentile.

Well Child Visits in the First 0-15 Months (W30-6) 2022—2024



For the W30-2 indicator, the final result of 72.86% did not meet the target of 77.78%, falling short by 4.92%. However, SFHP did slightly improve over the W30-2 baseline rate by 0.13%, maintaining the 2023 NCQA 66th percentile.

Well Child Visits in the First 15-30 Months (W30-2) 2022—2024



2.5.2.4 Recommendations

SFHP will discontinue the W30-2 measure in the QIHET Program and focus on other Clinical Quality – Behavioral Health measures. While SFHP will not be developing new interventions for this measure for 2025, SFHP will track and monitor the performance to ensure that the plan achieves at minimum the 66th percentile.

SFHP will continue the W30-6 measure in 2025 with a target of 63.29% to achieve the 2023 NCQA 66th percentile. Activities to support this measure will include:

- Establish supplemental data feeds to better align SFHP data with provider data.
- Expand the member incentive Plan-Do-Study-Act project at Zuckerberg Children's and Family Health Centers to test providing member gift cards in-person and at more visits.
- Incentivize providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care pay-for performance program.
- Provide gap in care reports to providers for members eligible for well-child visits.
- Promote and encourage members age zero to 15 months to engage in services through a member incentive to obtain well-child visits.

2.5.3 Topical Fluoride for Children (TFL-CH)

2.5.3.1 Overview & Performance

Measure: Topical Fluoride for Children (TFL-CH)					
Numerator	4,066	Baseline	17.77%	Final Performance	11.99%
Denominator	33,900	Target	19.30%	Evaluation Year	2024

The Topical Fluoride for Children (TFL-CH) measure is in the Engagement with Primary Care domain. This rate is based on the number of members one to 20 years of age who receive at least two topical fluoride varnish applications in the measurement year out of the total number of members one to 20 years of age. SFHP chose the target of 19.30% based on the CMS median for the measure as the measure is not benchmarked by NCQA.

2.5.3.2 Activities

The following activities were completed:

- Promoted and encouraged members age 12 to 47 months to engage in services through a member incentive to obtain fluoride varnish treatment. In 2024 SFHP provided 1,457 gift card member incentives, representing 33% of members eligible to obtain the incentive.

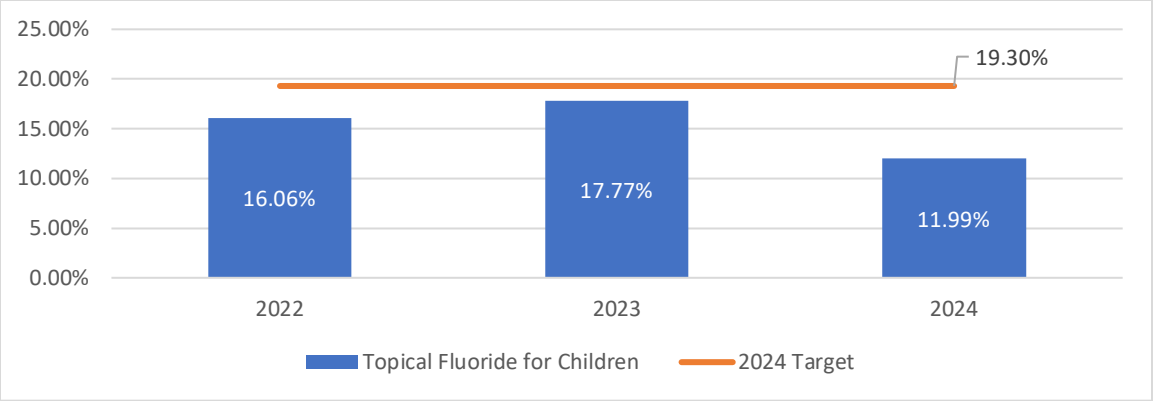
The following activities were not completed:

- Coordinate with SF Department of Public Health and local oral health coalitions to promote awareness of the importance of topical fluoride application in the primary care setting for all children from tooth eruption to five years of age and for older children and teens (up to 20 years) at risk of caries.
- Offer topical fluoride application training for those clinics requesting support.

2.5.3.3 Analysis

2.5.3.3.1 Quantitative

SFHP did not meet the target of 19.30%, falling short by 7.31% with a final result of 11.99%.



2.5.3.3.2 Qualitative

The main barriers to reaching the target were:

- Eligible population: current guidelines set by the United States Preventive Services Taskforce recommend fluoride varnish for children ages one to five, which is the focus of SFHP's primary care providers. DHCS requires the eligible population to be from one to 20. This misalignment of ages in recommendation, provider practice, and DHCS measurement & requirement proves difficult to improve the measure, particularly for members aged six to 20.
- Setting of care - service may be provided by dentists and/or PCPs and there may be a lack of coordination between settings to ensure members are receiving service. Additionally, as dental services are not managed by SFHP and instead are provided by Denti-Cal, SFHP does not have access to Denti-Cal data to determine if member is receiving the service in settings not managed by the health plan

The main barrier to completing planned activities was in staff capacity at SFHP, as other activities to support measures including W30-6 took priority over activities for TFL-CH.

2.5.3.4 Recommendations

SFHP will continue this measure in 2025 with a target of 19.00% to align with the CMS median. Activities to support this measure will include:

- Survey providers to understand best practices and identify areas for quality improvement at member or clinic level.
- Promote and engage members aged 12 to 47 months through a member incentive to obtain fluoride varnish treatment.
- Provide gap in care reports to providers for members eligible for topical fluoride treatment.
- Coordinate with SF Department of Public Health and local oral health coalitions to promote awareness of the importance of topical fluoride application in the primary care setting for all children from tooth eruption to five years of age and for older children and teens at risk of caries.

2.5.4 Initial Health Appointment

2.5.4.1 Overview & Performance

Measure: Initial Health Appointment					
Numerator	5,741	Baseline	21.00%	Final Performance	20.68%
Denominator	27,761	Target	35.00%	Evaluation Year	2024

The Initial Health Appointment (IHA) measure is in the Engagement with Primary Care domain. IHA is the percentage of new members enrolled in the prior 120 days who had a comprehensive PCP visit. SFHP chose the target of 35.00% for new SFHP members to receive an initial health appointment to demonstrate significant improvement from the baseline of 21.00%. SFHP included IHA in the QIHET Program and set an ambitious goal to prioritize resources to improve this measure; IHA was also included to represent a priority of SFHP's Population Health staff as SFHP has received corrective action from DHCS to address IHA.

2.5.4.2 Activities

The following activities were completed:

- Coordinated with provider groups by providing new member lists on a monthly cadence, communicated their performance, and made coding requirements clear and accessible to providers.
- Improved language in member materials and made IHA information more accessible on SFHP's website.
- Incentivized providers through inclusion of an Initial Health Appointment measure in SFHP's primary care pay-for-performance program.
- Incentivize new members to complete their IHA through a gift card raffle.

The following activities were not completed:

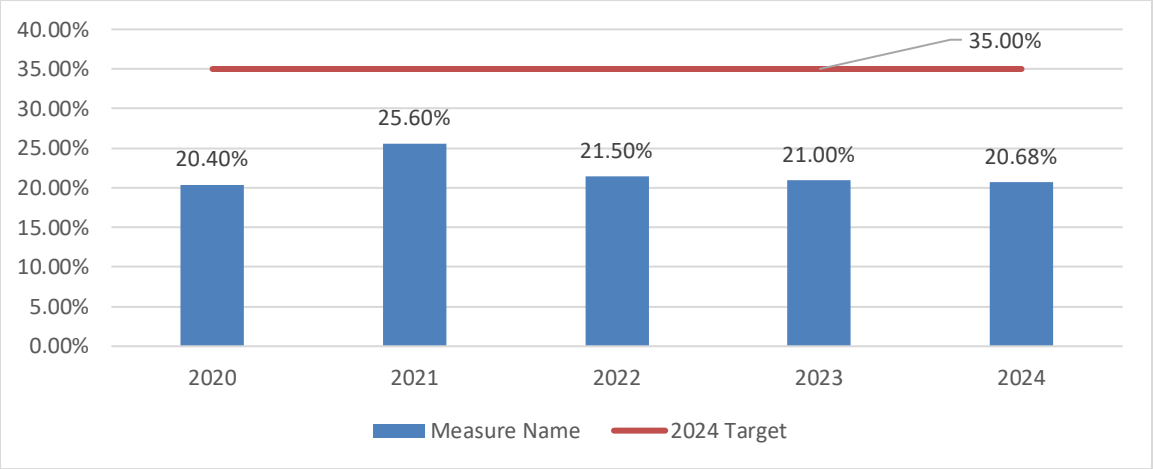
- Develop new outreach letter for members with no IHA on record 60 days after enrollment. This letter will remind members to schedule the appointment, how to contact SFHP with questions, and the importance of the IHA in their care.
    - Staff involved in this new outreach letter have made progress and the new outreach letter format will be completed and ready to implement in quarter one of 2025.

2.5.4.3 Analysis

2.5.4.3.1 Quantitative

SFHP did not meet the target of 35.00%, falling short by 14.32% with a final result of 20.68%.

Initial Health Appointment 2020 – 2024



2.5.4.3.2 Qualitative

SFHP convened an IHA Workgroup; the work group consists of cross-departmental leadership including Health Services, Marketing, Provider Network Operations, Compliance, and Business Analytics. In 2024, this team worked together to address the findings from the DHCS audit and Corrective Action Plan. One objective of this group is to review gaps needed to improve IHA rates. The team found improvements were needed by reporting IHA rates to delegated medical groups. Adequate reporting can support delegated medical groups with outreach to eligible members. The group also found education was needed for both providers and members. Additionally, another barrier the group found was the low accessibility of appointments available to new members.

The main barriers to improving IHA rates were in implementing activities that may not have had an impact on IHA. The following are the barriers associated with each activity:

- Member incentive raffle: The IHA Workgroup has not yet analyzed if the IHA raffle has had the intended impact of increasing IHA rates; this analysis will be undertaken in the first half of 2025.
- Timely notification of IHA member lists for delegated medical groups: these lists are now routinized and sent regularly so that groups can complete outreach. Despite this regular reporting to groups, this activity has not yet impacted IHA completion rates. After implementing the planned activities for 2024, the IHA workgroup found that the lists going to delegated medical groups were of members who had not completed their IHA within 120 days, which made it too late to do outreach.
- Timely notification of members: As a result of the above finding, staff implemented IHA procedures to initiate a member outreach letter to be sent at 60 days, when they are halfway through the IHA timeframe, if members have not yet completed their IHA. This letter is targeted to begin monthly mailing in quarter one of 2025.

2.5.4.4 Recommendations

SFHP will continue this measure in the 2025 QIHET Program as it is a priority of SFHP Population Health staff. Rates have not met our previous goal, indicating a need to continue. Furthermore, maintaining IHA as a measure shows our organizational commitment to improving

the IHA rate in this area. The target will be set at 22.75%, demonstrating a 10% relative improvement over 2024's rate.

Activities to support this measure will include:

- Incentivize providers through inclusion of an Initial Health Appointment measure in SFHP's primary care pay-for-performance program. Continue to offer a raffle to incentivize new members to complete their Initial Health Appointment.
- Incentivize providers through inclusion of an Initial Health Appointment measure in SFHP's primary care pay-for-performance program.
- Develop a Frequently-Asked-Questions document to serve as a resource for the provider for coding Initial Heath Appointments.
- Conduct delegated medical group audits of their Initial Health Appointment processes to identify opportunities for improved outreach and documentation.
- Provide member lists and group performance to network providers, aligned with provider data needs to conduct member outreach.
- Outreach via mail to members with no record of an Initial Health Appointment after 60 days after enrollment to educate the member on scheduling their appointment, how to contact SFHP with questions, and the importance of the Initial Health Appointment in their care.

2.5.5 PCP Engagement

2.5.5.1 Overview & Performance

Measure: PCP Engagement					
Numerator	89,967	Baseline	52.31%	Final Performance	55.53%
Denominator	162,008	Target	54.31%	Evaluation Year	2024

The PCP Engagement measure is in the Engagement with Primary Care domain. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care to better manage their health. Increasing the rate of members with a primary care visit may also support other QI & Health Equity program measures such as HEDIS and HP-CAHPS, as members with primary care visits are more likely to receive preventive care and care for chronic conditions. Members with a primary care visit have higher satisfaction with their health care as reflected in HP-CAHPS. The measure is the percentage of Medi-Cal members who did not have a PCP visit in the previous year who had at least one visit in the measurement year.

2.5.5.2 Activities

The following activities were completed:

- Incentivized providers through inclusion of a PCP visit measure in SFHP's primary care pay-for-performance program.
- Promote and encourage members to engage in services through member incentives for:

- Well-child visits in the first 15 months of life
- Developmental screening in the first 36 months of life
- Topical fluoride treatment for members 12 to 47 old
- Colorectal cancer screening
- Initial health appointments
- Prenatal or postpartum visits for pregnant members
- PCP visits for members with asthma, high blood pressure, or diabetes

2.5.5.3 Analysis

2.5.5.3.1 Quantitative

SFHP met the target of 54.31%, exceeding it by 1.22% with a final result of 55.53%.

2.5.5.4 Recommendations

SFHP will discontinue the PCP engagement measure in the QIHET Program and focus on other Engagement in Primary Care measures.

2.6 Member Experience

The domain of Member Experience involves activities related to improvement of care experience as measured by Health Plan CAHPS, experience or satisfaction of specific programs, Grievances & Appeals, Cultural and Linguistic Services, Health Education, Community Supports and member materials.

2.6.1 HP-CAHPS

2.6.1.1 Overview & Performance

Measure: HP-CAHPS – Getting Needed Care					
Numerator / Denominator Care, Tests, & Treatment	207/ 274	Baseline	69.80%	Final Performance	69.21%
Numerator / Denominator Specialty Care Access	105/ 167	Target	72.80%	Evaluation Year	2024
Measure: HP-CAHPS – Rating of Personal Doctor					
Numerator	223	Baseline	64.54%	Final Performance	67.58%
Denominator	330	Target	67.54%	Evaluation Year	2024
Measure: HP-CAHPS – Rating of Specialist					
Numerator	102	Baseline	64.38%	Final Performance	66.67%
Denominator	153	Target	67.38%	Evaluation Year	2024

Getting Needed Care, Rating of Personal Doctor, and Rating of Specialist represent questions within the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey, which assesses member experience of care; these measures are part of the member experience domain. HP-CAHPS performance is important to SFHP because it is the

primary means by which members provide feedback about their satisfaction with SFHP and their overall health care. SFHP strives for high member satisfaction in addition to high quality and affordability.

HP-CAHPS – Getting Needed Care is the total number of members who responded to the Getting Needed Care composite responding with 'usually' or 'always' to the composite of two questions: "In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?". SFHP set a target of 72.80% based on 3.0% absolute improvement from baseline from measurement year 2023. HP-CAHPS – Rating of Personal Doctor is the total number of members who responded to the Rating of Personal Doctor question responding with '9' or '10' to the question: "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?". SFHP set a target of 67.54 based on 3.0% absolute improvement from baseline from measurement year 2023. HP-CAHPS – Rating of Specialist is the total number of members who responded to the Rating of Specialist question responding with '9' or '10' to the question: "We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?". SFHP set a target of 67.38 based on 3.0% absolute improvement from baseline from measurement year 2023.

2.6.1.2 Activities

The following activities were completed:

- Conducted informational interviews with Primary Care Providers to gauge clinics' approaches to Telehealth communication and scheduling in the Primary Care setting.
- Implemented a telehealth education campaign to increase awareness and utilization of SFHP's telehealth services, with a focus on African Americans and Spanish-speaking members.
- Incentivized providers through inclusion of CAHPS measure: Rating of Personal Doctor in SFHP's primary care pay-for-performance program.
- Incentivized Zuckerberg San Francisco General providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.
- Provided funding to Zuckerberg San Francisco General Specialty Care Providers to implement appointment access interventions.
- Collaborated with network providers who work in care experience to align priorities & strategy, and work on shared initiatives.
- Included a health equity measure component in SFHP's primary care pay-for-performance program to incentivize Providers participating in this activity conducted telehealth quality improvement & health equity activities for the measure for members who are Hispanic or Latino or Black or African American. Five community clinics (Equity Health, Lyon Martin Community Health Services, Marin City Health and Wellness Center at Bayview Hunters Point, Native American Health Center, and San Francisco Health & Wellness Center) participated in this health equity initiative.
- Created a 5-step guide to understanding specialty referrals by medical group for members.

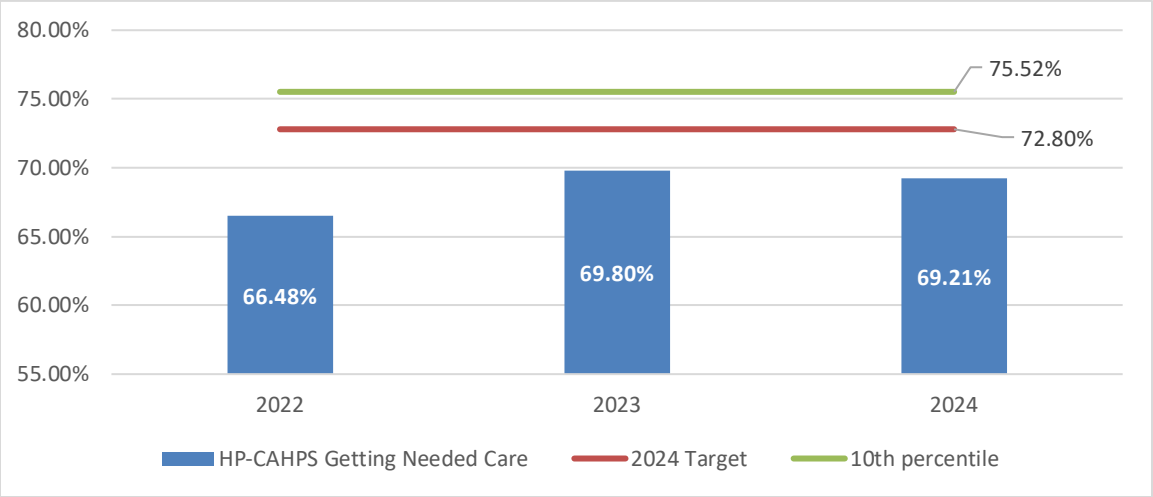
- Provided network providers and staff training on racial equity

2.6.1.3 Analysis

2.6.1.3.1 Quantitative

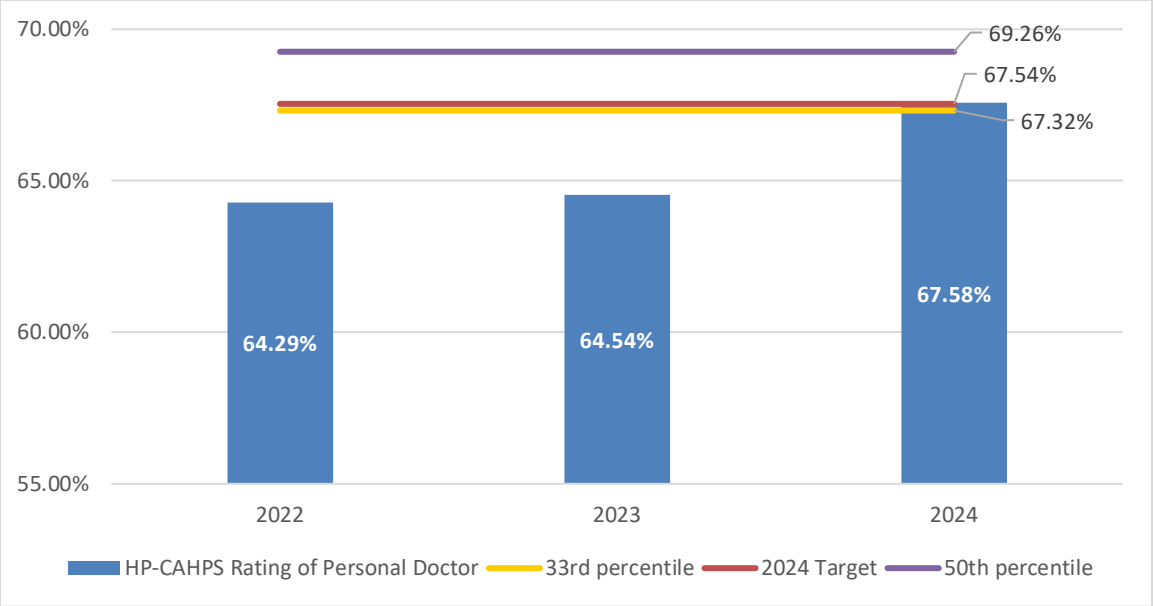
The HP-CAHPS Getting Needed Care measure did not meet the target. Performance decreased by 0.59% - from 69.80% to 69.21% - and achieved below the 10th percentile ranking for Medicaid health plans. The following chart demonstrates the three-year trend in HP-CAHPS Getting Needed Care scores with comparison to 2023 NCQA Medicaid percentile benchmarks and to the 2024 target.

HP-CAHPS Getting Needed Care 2022 – 2024



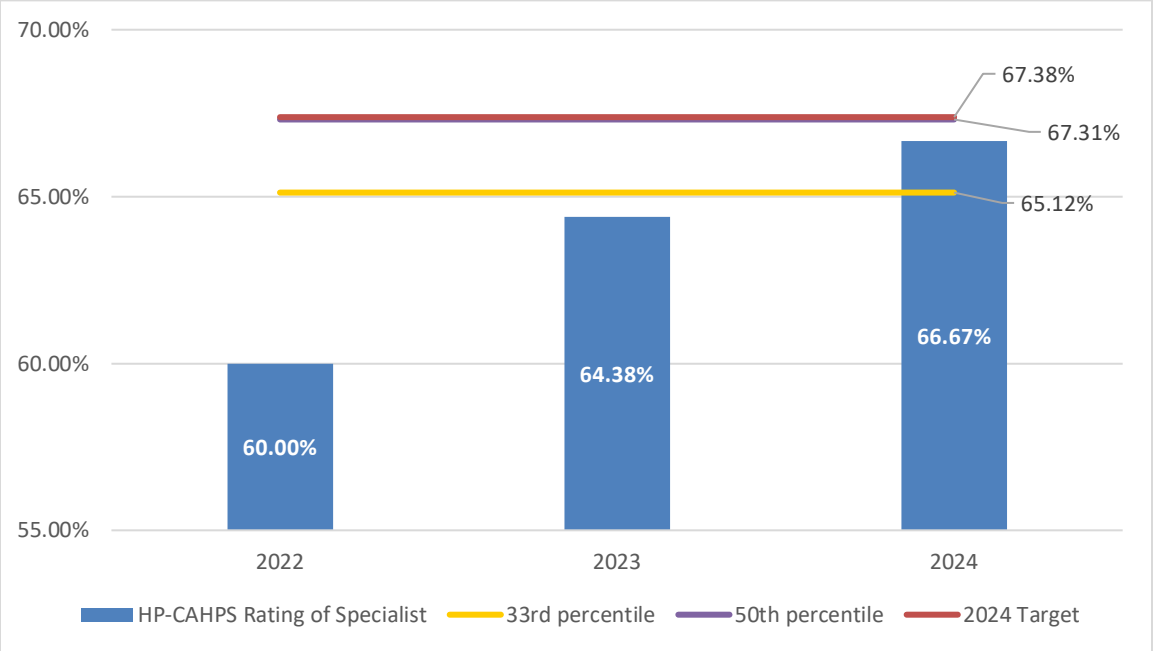
The HP-CAHPS Rating of Personal Doctor measure met its target. Performance increased by 3.04% - from 64.54% to 67.58% - exceeding the target and achieving the 33rd percentile ranking for Medicaid health plans. The following chart demonstrates the three-year trend in HP-CAHPS Rating of Personal Doctor scores with comparison to 2023 NCQA Medicaid percentile benchmarks and to its 2024 target.

HP-CAHPS Rating of Personal Doctor 2022 – 2024



The HP-CAHPS Rating of Specialist measure did not meet the target. Performance increased by 2.29% - from 64.38% to 66.67% - and achieved the 33rd percentile ranking for Medicaid health plans. The following chart demonstrates the three-year trend in HP-CAHPS scores with comparison to 2023 NCQA Medicaid percentile benchmarks and to its 2024 target.

HP-CAHPS Rating of Specialist 2022 – 2024



2.6.1.3.2 Qualitative

Barriers to greater improvement across these measures include:

- Members experience difficulty accessing primary care, in particular for those who do not have a PCP.
- The quality of interpreter services for members whose primary language is not English is not consistent in primary care or other care settings.
- Inability to schedule an appointment within a reasonable amount of time is a consistent issue.

2.6.1.4 Recommendations

SFHP will discontinue the Rating of Personal Doctor and Rating of Specialist measures in the QIHET Program and focus on other Member Experience measures. SFHP will continue to track and monitor the performance of these measures.

SFHP will continue the Getting Needed Care measure in 2025 with a target of 75.52% to achieve the 2023 NCQA 10th percentile. Activities to support this measure will include:

- Improve workflows and system efficiencies for Durable Medical Equipment across vendors, referring providers, and the health plan.
- Deliver a digital, multi-month HP-CAHPS education and awareness campaign for members focused on ways to access specialty care and vision services as well as how to complete the HP-CAHPS survey if randomly selected to participate.
- Design and deliver member experience survey for dual-eligible beneficiaries to establish baseline and develop early strategy for care experience improvement in preparation for 2026 D-SNP.
- Complete network analysis to understand trends and barriers to accessing specialty care and develop an intervention to address identified barriers.
- Incentivize providers through inclusion of HP-CAHPS Care Experience measures in SFHP's primary and specialty care pay-for-performance programs.

2.6.2 Care Management Client Satisfaction

2.6.2.1 Overview & Performance

Measure: Care Management Client Satisfaction					
Numerator	55	Baseline	62.79%	Final Performance	94.83%
Denominator	58	Target	65.00%	Evaluation Year	2024
Measure: Complex Care Management Client Satisfaction					
Numerator	27	Baseline	86.00%	Final Performance	96.43%
Denominator	28	Target	100.00%	Evaluation Year	2024

The Care Management Client Satisfaction measure is in the Member Experience domain. This measure reflects activities to increase the percentage of clients enrolled in SFHP's Care Management (CM) and Complex Care Management (CCM) programs who respond "Yes" to

Question 2: ‘Has the Care Management program helped you reach your health goals?’ and who respond “Always” or “Often" to Question 6: ‘After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.’ The client satisfaction survey is conducted twice a year and is used to assess client experience with CM services and staff. This measure represents SFHP’s commitment to ensuring that Care Management programs are member centered. The target for this measure was 65.00% (CM) and 100.00% (CCM) and was chosen based on incremental improvement from the previous measurement year.

2.6.2.2 Activities

The following activities were completed:

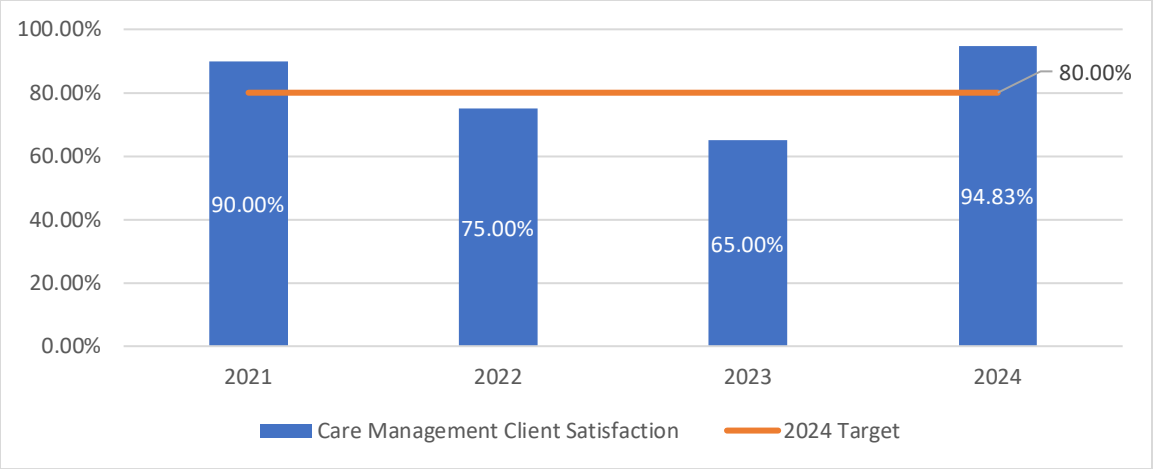
- CM staff completed six-month reassessments and reviews of care plans, including goals with members.
- Developed individualized case management plans, including members’ prioritized goals and preferences.
- Improved communication of care plan goal progress between Care Management staff and members.
- Included online resources in Case Management software system for easier access by CM Coordinators and Nurses.
- Initiated a Closed Loop Referrals project to seek a system for connecting members to needed resources.
- Maintained a process to triage members into longer-term case management programs when requested by member or indicated by member’s self-efficacy skills.
- Provided more thorough life skills, health education and training to members pertaining to self-management of their conditions and their health maintenance.
- Strengthened relationships with community based organizations and increased team knowledge of community resources.

2.6.2.3 Analysis

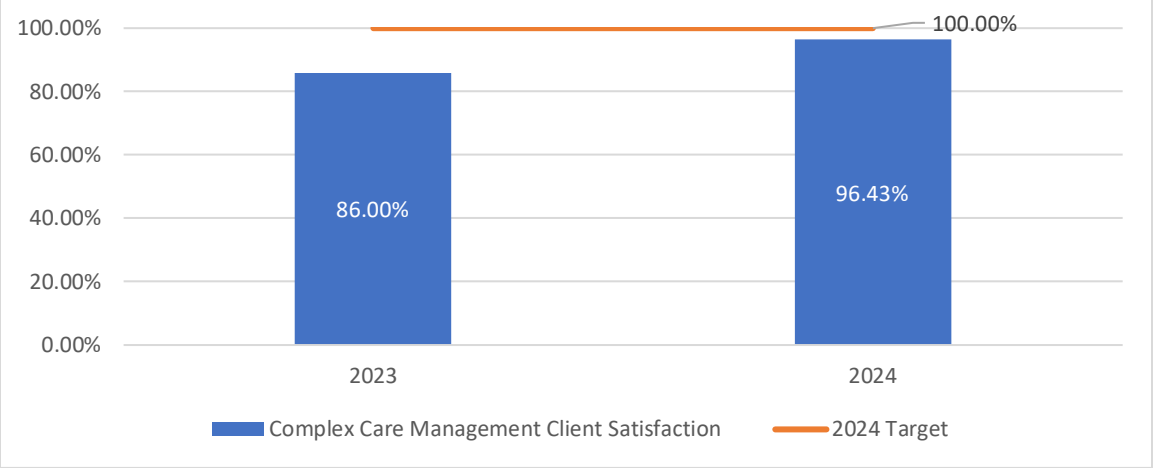
2.6.2.3.1 Quantitative

SFHP met the Care Management target of 65.00%, exceeding it by 29.83% with a final result of 94.83%. However, SFHP did not meet the Complex Care Management target of 100.00%, falling short by 3.57% with a final result of 96.43%. The following charts demonstrate the year over year trend in the rate of members with Care Management Client Satisfaction and Complex Care Management Client Satisfaction.

Care Management Client Satisfaction 2021 – 2024



Complex Care Management Client Satisfaction 2023 – 2024



2.6.2.4 Recommendations

SFHP will discontinue the CM & CCM Client Satisfaction measures in the QIHET Program and focus on other Member Experience efforts. SFHP's Care Management staff will continue to work to monitor members' satisfaction with their services.

2.6.3 Provider Directory – Race and Ethnicity

2.6.3.1 Overview & Performance

Measure: Provider Directory – Race and Ethnicity					
Numerator	455	Baseline	1.59%	Final Performance	4.16%
Denominator	10,942	Target	8.00%	Evaluation Year	2024

The Provider Directory – Race and Ethnicity measure is in the Member Experience domain. The goal of this measure is to collect the organization's provider data to determine the race/ethnicity of providers. SFHP chose the target of 8.0% for provider race or ethnicity based on 6.4% absolute improvement from 2023. The goal of this measure is to obtain voluntary race and ethnic identity information from providers so that if members prefer to have racial/ethnic concordance with their providers, they can choose a provider based on the information SFHP collects and publishes in SFHP's provider directory. Provider Directory – Race and Ethnicity is the total number of providers voluntarily submitting their race or ethnic identity out of the total number of providers contracted in SFHP's network. SFHP chose the target of 8.0% based on incremental improvement from the previous measurement year.

2.6.3.2 Activities

SFHP completed the activities listed below:

- Engaged provider groups in collecting data from their clinicians.
- Conducted a communication campaign to network providers to encourage providers to volunteer race and ethnicity information.
- Explored offering a provider incentive for collecting race and ethnicity information.
    - While SFHP's pay-for-performance program incentivizes providers for submitting correct provider information, SFHP chose to not include race and ethnicity as a data element requirement for this incentive.
- Integrated race and ethnicity data collection with credentialing data for some credentialing bodies.

2.6.3.3 Analysis

2.6.3.3.1 Quantitative

Data is based on the provider's information collected during the credentialling process. SFHP did not meet the 8.0% for collecting provider race/ethnicity data with a final rate of 4.16%.

2.6.3.3.2 Qualitative

A barrier to meeting the race and ethnicity data target is due to this information not being routinely collected through the credentialling process. The data is voluntarily reported and there is no incentive. The number of credentialed clinicians who provided their race/ethnicity improved most likely due to our education efforts over the last year.

2.6.3.4 Recommendations

SFHP will discontinue the Provider Directory – Race and Ethnicity measure in the QIHET Program and focus on other Member Experience efforts. SFHP's Provider Network Operations staff will continue to work to monitor providers' voluntary submission of this information.

3. Quality Oversight Activities

These are quality oversight activities monitored and completed this year.

	Oversight	Summary	Responsible Staff	Activities	Due Date
A	Quality Improvement & Health Equity Committee	Ensure Quality Improvement & Health Equity Committee (QIHEC) oversight of QIHE activities outlined in the QIHET Workplan	CMO CHEO	• Four meetings held in 2024	12/30/2024
B	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	• Quarterly and ad hoc P&T Committee meetings	12/30/2024
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	• Five meetings held in 2024	12/30/2024
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	• Eight meetings held in 2024	12/30/2024
E	Annual Evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP)	Review QIHETP and determine efficacy of implemented plan based on outcomes	CMO	• Evaluated each measure in the QIHETP work plan • QIHEC reviewed QI evaluation • Governing Board reviewed QIHTP Evaluation	3/27/2024
F	QIHETP Plan Approval for Calendar Year	Review and approve proposed Quality Improvement & Health Equity Transformation work plan	CMO	• QIHEC reviewed QIHETP work plan • Governing Board reviewed QIHET Work Plan	3/27/2024

	Oversight	Summary	Responsible Staff	Activities	Due Date
H	DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects	CMO	• Attended DHCS-led Performance Improvement Project calls • Adhered to process delineated by DHCS	12/30/2024

Reviewed and Approved by:

Chief Medical Officer: *Steve O'Brien, MD* Date: 2/20/2025

Chief Health Equity Officer: *Edwin Poon, PhD* Date: 2/20/2025

Quality Improvement & Health Equity Committee Review Date: 2/20/2025

Board of Directors Review Date: 3/19/2025